May 22, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1021-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Psychiatry. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This is a case of a 24-year-old female who suffered a lower back injury on ___ while working at___. Since the injury, she continues to complain of low back pain that radiates down her legs, left leg parathesias, insomnia and depression. Her initial treatment with physical therapy (two months) and medications (Zanaflex, Norco, Bextra, Oxycontin, Vioxx, Vicodin, Soma, Celebrex, Naproxen, Skelaxin, Ultram,Restoril, Doxepin and Ambien) was unsuccessful. She then had three lumbar steroid injections that gave her only four weeks of relief in May of 2002. Her MRI performed on 1/11/02 had shown some evidence of disc dessication and degeneration. Her physicians requested further evaluation and treatment to include a discogram, enrollment in a multidisciplinary pain program, psychiatric evaluation/testing and more steroid injection. These requests were denied, the denial presumably was based on ___ assessment that the patient has no pathology on his exam to explain the persistent subjective complaints of pain. Despite ___ suggestion that she could have a somatoform disorder, he did not recommend any psychiatric evaluation to test for this.

REQUESTED SERVICE

A psychological evaluation is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds that psychiatric evaluation and psychological testing is indicated and medically necessary for this patient who has persistent pain and signs of depression. It is quite possible that this patient developed depression over the prolonged course of non-recovery from her original injury. The depression could be increasing her pain symptoms. It is well known that psychiatric treatment with psychotherapy and antidepressant medications can help reduce pain symptoms in chronic pain patients. It would be very helpful to get psychological tests done to help evaluate this patient's personality. Certain personality traits are associated with pain complaints of greater severity than what physical examination would predict. If the testes indicate a personality prone to somatic complaints, it would underscore the need for conservative physical treatment and concomitant psychiatric/psychological care. To deny or neglect psychiatric evaluation/treatment for a chronic pain patient who appears depressed and has failed eighteen months of standard physical care is inappropriate.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 22nd day of May 2003.